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SOME NOTEWORTHY HYSTERECTOMIES: A RETROSPECTIVE REVIEW.*

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The cases upon which this paper is based have been to me most instructive, and now that they are before me, grouped and classified, it is easy to glance down the list and recall the incidents of interest in each and to see, with the clearer vision distance gives, the group as a whole, and each case as it stands in relation to the others.

Those who do most abdominal work know best that unexpected conditions often present themselves, and that accidents and a certain mortality must of necessity accompany the work in the most skillful hands.

To operate only on selected and favorable cases is an injustice to the critical ones. What is apparently a most desperate case will often make a most gratifying recovery after operation, and that patient is entitled to receive the benefit of the doubt, regardless of the operator's desire to make a clean record.

With what are usually considered unfavorable cases, my habit is to state the case as it is, in my opinion, and the chances with or without operation, and then have the patient and family decide for themselves, without persuasion, what shall be done. By far the most gratifying cases of my whole experience have been the very desperate ones so treated, for they not uncommonly recovered after operation.

Do not fancy that the foregoing remarks are to prepare you to listen to a series of statistics for which apology must be made before the cases are presented. The mortality of this series is not high, and

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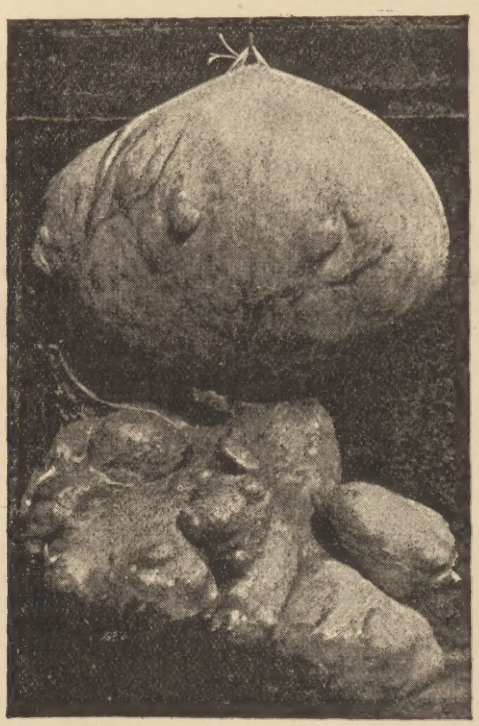
taking into account the grave nature of the diseases for which the operations were done, the results are exceptionally good. It is because I am pleased with the results that I can the better afford to analyze my methods.

Around the operation of hysterectomy is clustered much of the gynæcological controversy of to-day. There are extreme advocates



CASE I.—Multiple fibroid of the uterus, weighing 14½ pounds.

and extreme opponents of hysterectomy, each with the assurance that he only is right, while the truth undoubtedly lies in the middle ground which neither occupies.

The extravagant surgical tendencies of the times have caused us to take steps which must of necessity be partly retraced, although it should meanwhile be remembered that the truest conservatism is often to be found in the most radical proceeding.

Indiscriminate hysterectomy in all cases where a fibroid tumor exists in a uterus, in all cases where it has become necessary to re-

move the ovaries and tubes for any cause, in all cases of prolapsus of the uterus of the third degree, and in all cases of suspicious erosion of the cervix, with hæmorrhage, will not be sanctioned by those gynæcologists best qualified to express a valuable opinion, and will be openly and vigorously condemned by that large body of eminently practical men, the general practitioners.

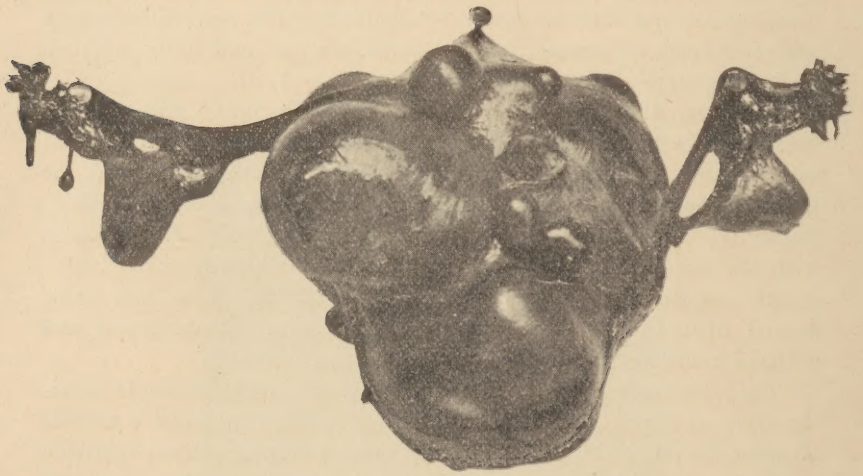
The first five cases I have to report were cases with uterine fibroids. They were all operated upon by the supravaginal amputation method, in one of them the Kœberlé serre-nœud being used, the others having the arteries ligatured and the peritoneal flaps approximated over the stump of the cervix (Baer's operation). All recovered with the exception of Case III, and all those making recoveries were greatly improved as to symptoms and disability. One had some mental disturbance before operation which was not improved, and perhaps made worse.

The case treated by the nœud had an enormous multiple intraligamentous fibroid tumor, in which it was difficult to make a pedicle on which to place the wire. She had been taking morphine, had been a chronic invalid for years, with tremendously swollen legs and œdematous belly, unable to lie down day or night. She demanded operation for relief, knowing that the chances were all against recovery, as her belly had been previously opened by one of the best abdominal operators in this country, and the removal of the tumor abandoned.

This experience with the serre-nœud was, however, my last, for soon after operating on this case I had the pleasure of seeing Dr. B. F. Baer do a hysterectomy with the ligature, and its advantages were so evident that I at once adopted it, and have continued to use it.

Case III was also a large intraligamentous fibroid tumor. Its enucleation was very difficult, but was successfully accomplished, and the operation finished to my entire satisfaction. She came out of the ether well and did well for a day, when her pulse and temperature rose and she began to vomit brown froth and mucus · no gas or fæces could be passed from the rectum, and she died on the fourth day. No autopsy could be procured, and it was a question what caused the peristaltic paralysis, fæcal regurgitation, and subsequent death ; but my present knowledge of these things leads me to believe that in some way a septic peritonitis must have developed, though I am unable to recall any fault in the preparation of the patient or the technique of the operation. However, the operation was done at

her home, and I take this occasion to repeat what I have said before—that in all such grave cases all the risks are greatly increased in opera-



CASE III.—Multiple intraligamentous uterine fibroid.

tions done at home over those done at a well-equipped and well-managed hospital.

CASE IV was a large fibroid tumor. The operation and convalescence were uneventful, except that she had some dribbling of urine beginning about three weeks after the operation. A silk ligature was found piercing the vault of the vagina and bladder. It must have been the one placed on the left uterine artery, which had taken in more tissue than was intended or necessary, and was now ulcerating its way out through the vagina. All dribbling ceased after its removal. The other fibroid cases made uneventful recoveries.

CASE VI was a woman who had been bleeding profusely for several days and was also profoundly septic, as the result of a self-induced abortion. The uterus had not been emptied, and she had great abdominal pain and distention, chills, fever, and sweats, and was very weak. Hysterectomy (supravaginal) was thought to offer her the only chance for recovery and was promptly done. No time was lost, no complications were encountered, excepting that it was difficult to satisfactorily place the ligatures upon the uterine arteries as the tissues seemed soft and gave way in the grasp of the loops. She went from the operating room in fair condition, but soon collapsed, and died four hours after operation. At the autopsy she was found to

have had some secondary hæmorrhage from the right pedicle, which in her already bloodless condition she could not withstand. The uterus contained a putrid fœtus and placenta, and its walls were extremely soft and riddled with pus foci.

Hysterectomy for sepsis after labor and abortion has had a large mortality, and always must have. The grave character of the cases and the progress the disease is apt to have made before operation is likely to be considered, prejudice the prospect. It surely has a legitimate field, however, and its early performance will save some lives which must otherwise be lost.

Cases VII and VIII were also done by the supravaginal method. In both cases the uterus, tubes, and ovaries were bound down by dense adhesions; in one case a cyst of the left ovary, and in the other enormous tubal abscesses, complicated the work. Each uterus was enlarged and soft, and pouring into the vagina a free flow of pus known to be gonorrhœal in one case. Both cases recovered promptly and completely. The chances of recovery and subsequent comfort would not have been so good had I removed only the ovaries and tubes. One has only to glance into the pelvis after this supravaginal amputation to appreciate its advantages—*i. e.*, the removal of all the diseased organs and the smooth surface of peritonæum covering nearly all raw surfaces and pedicles.

Complete hysterectomy by cœliotomy was done three times, all the patients recovering. In one case in which the operation was done for cancer the disease reappeared in the right breast. She subsequently came into the hospital, and I removed this breast and the axillary glands. Another one had been long in bed, and was found to have densely adherent pus tubes and uterus with a fibroid tumor of the uterus and a suspicious erosion of the cervix. She was restored to perfect health, and gained rapidly in flesh and strength after complete hysterectomy.

Two complete vaginal hysterectomies deserve mention, one being done for cancer involving the base of the bladder as well as the cervix, and the other for cystic and prolapsed ovaries and a retroverted and badly lacerated uterus in a woman with a contracted pelvis.

In the first of these cases it was necessary to remove about two square inches of the base of the bladder to completely remove all diseased tissue; the resulting vesico-vaginal fistula was closed at a subsequent operation, as was also an old complete tear of the perinæum which extended well above the rectal sphincter. She recovered perfect control of the urine and fæces, and has had no return of her

cancer, though more than two years have elapsed since the hysterectomy was performed.

The second case made it necessary to choose between an oöphorectomy by cœliotomy with repair of the cervix, or complete removal of the uterus and appendages by the vagina. The vaginal operation was chosen for the reason that it seemed the safer and better. In this case the radical operation was the more conservative, and I am sure gave results no other could have done. This patient recovered promptly and completely, notwithstanding an accident in the removal of the gauze drain through the vault of the vagina. A loop of small intestine which had become attached to the gauze was drawn down into the vagina, and had to be detached and replaced. Aside from a rise of temperature, no ill effects followed.

The patient had had two very difficult instrumental deliveries of dead babies, her pelvis was contracted, and the lesions in the ovaries and uterus, taken together with her history of almost total disability for work or recreation, made conditions which fully warranted the procedure adopted.

Now let me go rapidly over the list and deduct the lessons from each of these cases.

Cases I, VI, VIII, and XII were desperate—all cases with the probabilities greatly against success. Of those, one case (VII) died. It is a question whether she would not have recovered had she not suffered from the secondary hæmorrhage. Case I was a brilliant triumph of modern scientific surgery, and teaches that none of us are infallible; that when one abdominal surgeon closes up the belly and abandons a tumor, another may at a later time and under other circumstances successfully accomplish its removal.

Case XII demonstrates what can be done by bold and truly conservative work. The removal of the uterus would have done little good had the disease not been followed up and the base of the bladder excised. The secondary plastic work in this case was perfectly successful and satisfactory, and up to the present time there has been no return of the disease, though more than two years have elapsed.

Case VIII was a dreadfully ill woman, and operation seemed scarcely to be worth considering, but, as it offered the only chance for her life, and she desired it (after a statement of the case), it was done. The tubes and ovaries were disorganized and blended into two extensive abscess sacs, the pelvis was packed with lymph and exudate, and the uterus was enlarged, soft, and boggy. She was emaciated to a dreadful degree and saturated with sepsis. After operation she began

to improve at once ; the next day after her operation her temperature went down to 99.2°, though it had not been below 101° for many days before, and it did not subsequently get up to 100°. Her convalescence was without pain or disturbance, and her only complaint was that she was hungry, which was not remarkable, as she had eaten almost nothing for weeks.

This case and Case X (also a pus case) convinced me of one important point I had long believed to be true as to drainage, and the risk of peritonitis after operation. In both of these cases the peritonæum was soiled at the time of the operation with the foul, stinking pus, notwithstanding the careful placing of a gauze dam to guard against it.

The pus was simply wiped away, and no irrigation and no drainage used. No infection occurred ; in fact, the convalescence was unusually free from pain and disturbance.

When the peritonæum has been subjected to periodical leakage of pus, as in these cases, there is, in my opinion, an acquired immunity to serious infection, and irrigation and drainage are unnecessary, for even virulent pus can be taken care of by this trained membrane. If abdominal surgeons will recall, or look up, their cases of post-operative peritonitis, I believe they will find them to have happened in most instances when no pus was to be found—in ventro-fixation, fibroids, ectopic gestation, etc. These remarks apply as well to recurrent appendicitis with abscess, where I have observed like conditions.

Therefore the examination of pus microscopically, to settle the question of drainage, seems to me as unnecessary as it is unwieldy. In my opinion, the use of tubes for abdominal drainage is irrational and unnecessary, and the use of gauze *for drainage purposes only* is just as unreasonable.

This case then confirms my opinion about the conservatism of Nature's processes, and what she can do in the way of recuperation if you but give her a chance.

The dusky, lusterless, and congested peritonæum one finds in most of these pus cases is not easily inflamed, and its absorptive powers are so impaired, and such a degree of immunity has been established, that tolerance and protection are assured to a wonderful extent.

The most satisfactory way to treat them is to wall off the field of operation with a gauze dam, for the protection of the adjoining tissues, and the absorption of the overflow, then wipe away any pus that may have passed the dam and close the wound.

Of these four unpromising and desperate cases, three recovered and one died, a proportion of recoveries calculated to stimulate one's desire to do his best for each individual case and let his statistics show what they may.

Case II reaffirms the well-known fact that the form of insanity which is often associated with uterine fibroid is rarely cured, or may be made worse by the operation of hysterectomy, or, in fact, any other surgical interference. If operations are done in these cases, it is well to inform the family of this danger.

Case IV teaches that the ligature of the uterine artery must be placed with great care to avoid penetrating the bladder and vagina. Stone in the bladder, with a silk ligature as a nucleus, has followed this accident. My method of placing the ligatures was entirely changed after this occurrence. Now let us make some comparisons of these various methods of doing hysterectomy, and see what conclusions these varied cases lead to.

First, all but a very few of the more prominent gynæcologists of the world have abandoned the use of the nœud, rubber ligature, and clamp for what, in their opinion, is some better method of hæmostasis ; that leaves us the supravaginal amputation (Baer's method) and the total hysterectomy by cœliotomy or by the vagina for comparison and comment.

That conditions occur in which either of these methods would be the operation of choice is, of course, true. This series of cases aptly illustrates that point, but there are distinct advantages and disadvantages about each which must be borne in mind.

Baer's method is easier of accomplishment than total hysterectomy by cœliotomy, it can be done in less time, and, where there is no distinct reason for the removal of the cervix (as in cancer), it is a decided advantage, and no disadvantage to leave it. As Baer has said, it acts as the keystone of the arch of the vagina and prevents much subsequent mischief. The point of great importance in my opinion, and the one which has been too little dwelt upon, is the preservation of a normal vagina. Perhaps the point most strongly impressed upon me in this lot of cases was the shallow, and ever-growing shallower, vagina after complete hysterectomy, vaginal or by cœliotomy. This is a most important point in the consideration of this question, and for a married woman, or one likely to marry, only the most urgent reasons should determine for the practical obliteration of this canal. Other things being equal, I would certainly choose the Baer operation in preference to total hysterectomy by cœliotomy.

No.	Disease.	Method of operating.	Result.
I.	Multiple intraligamentous uterine fibroid	Supravaginal amputation and serre-nœud.	Recovery.
II.	Large uterine fibroid.	Supravaginal amputation and ligature by Baer's method.	"
III.	Multiple intraligamentous uterine fibroid.	Do.	Died.
IV.	Uterine fibroid.	Do.	Recovery.
V.	" "	Do.	"
VI.	Sepsis and acute anæmia after self-induced abortion.	Do.	Died.
VII.	Cyst of ovary and septic metritis.	Do.	Recovery.
VIII.	Pyosalpinx and septic metritis.	Do.	"
IX.	Cancer of the body of the uterus.	Complete hysterectomy by cœliotomy.	"
X.	Pyosalpinx, small uterine fibroid, and suspicion of cancer.	Do.	"
XI.	Prolapsus and contraction of os after amputation of cervix.	Do.	"
XII.	Cancer of cervix and base of bladder.	Vaginal hysterectomy.	"
XIII.	Cyst of ovaries, prolapsus, bilateral cervical laceration, contracted pelvis.	Do.	"

Vaginal hysterectomy has quite a different field, and when it is indicated at all, it is usually clearly the operation of choice. The vaginal route for tubal and ovarian diseases is now chosen by some of our best men, and the uterus is often incidentally removed in the process. The advantages of this route to reach the appendages are not clear to me, and I shall look for some revulsion of feeling when the novelty has worn off ; and largely I believe on account of the point I have made, that of ultimate obliteration of the vagina when the whole uterus is removed. As nearly as it can be generalized, I should choose my methods of hysterectomy about as follows :

1. With the serre-nœud or rubber ligature very rarely, and only in cases of great emergency where time of operation must be very short, and not an unnecessary drop of blood lost.

2. Total hysterectomy by cœliotomy when it is necessary for any reason to go in from above the symphysis pubis, and also necessary, on account of cancer or other disease, to remove the whole uterus.

3. Baer's operation (supravaginal amputation) in all other cases where hysterectomy by cœliotomy becomes necessary—*i. e.*, large, not malignant fibroids, septic tubo-ovaritis with a large, boggy, infected

uterus, and in hysterectomy of the pregnant uterus before and after delivery, etc.

4. Vaginal hysterectomy for cancer or sepsis, and all other conditions *where hysterectomy is necessary* and the size of the organ permits of its removal by the vagina, excluding those cases in which dense adhesions of bowels or other viscera would make a cœliotomy preferable for the purpose of securing a clean and complete removal of all diseased tissues and the repair of damaged or torn viscera.

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